STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295020	A. BUILDING _____ B. WING _____	C 11/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD REHABILITATION CENTER	**2045 SILVERADA BLVD. RENO, NV 89512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

Surveyor: 13132
This Statement of Deficiencies was generated as the result of four complaint investigations conducted at your facility on 11/9/05.

Complaint # NV00009928 was a facility reported incident of an altercation between two residents. There were no injuries as a result of the incident. The incident was substantiated, but no deficiencies were cited based on the facility's actions.

Complaint # NV00009937 was a facility reported incident that a resident slid to the floor from a wheelchair. There were no injuries as a result of the incident. The incident was substantiated, but no deficiencies were cited based on the facility's actions.

Complaint #NV00009938 was a facility reported incident of an altercation between two residents. There were no injuries as a result of the incident. The incident was substantiated, but no deficiencies were cited based on the facility's actions.

Complaint # NV00009977 was a facility reported incident of two altercations between the same two residents on separate occasions. There were no injuries as a result of the incidents. The incident was substantiated, but no deficiencies were cited based on the facility's actions.

The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295020	A. BUILDING _____ B. WING _____	C 11/09/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWOOD REHABILITATION CENTER	**2045 SILVERADA BLVD. RENO, NV 89512**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 state or local laws.	F 000		